EXHIBIT 14

aetna®

Jennifer Barrett
Agency for Health Care Administration
Mailroom
Building 2, 1st Floor, Suite 1500
2727 Mahan Drive
Tallahassee, FL 32308-5403

Date
October 16, 2017

Laurie Brubaker
Chief Executive Officer
Aetna Medicaid
4500 E. Cotton Center Blvd.
Phoenix, AZ 85040
Phone: 602-659-1160

AETNA BETTER HEALTH® OF FLORIDA

RE: AHCA ITN 002-17/18

To Whom It May Concern:

Coventry Health Care of Florida, Inc. dba Aetna Better Health® of Florida (Aetna) is pleased to present its response to the State of Florida, Agency for Health Care Administration for Solicitation Number AHCA ITN 002-17/18-Region in Region 2 for the Statewide Medicaid Managed Care Program.

We authorize release of the redacted version of our response to the Invitation to Negotiate in the event the Agency receives a public record request.

The following is our general information: Coventry Health Care of Florida, Inc.
dba Aetna Better Health of Florida
1340 Concord Terrace, Sunrise, Florida, 33323

The following is our tax identification number: 65-0986441

We consider it a privilege to serve Florida's most vulnerable citizens. We have partnered successfully with the State to transform positively the health and well-being of its Medicaid enrollees. As we look to the future, we are excited about the innovative ways in which we can continue to collaborate with AHCA to improve member-centric, integrated care delivery, to meet the diverse needs of all the Floridians we will serve, and to meet State goals.

Sincerely,

Laurie Brubaker

Laurie Brubaker
Chief Executive Officer
Aetna Medicaid
4500 E. Cotton Center Blvd.
Phoenix, AZ 85040
(602) 659-1160
BrubakerL2@Aetna.com

Heidi E. Garwood

Heidi E. Garwood, ESQ
Chief Executive Officer for Florida Aetna Medicaid
Coventry Health Care of Florida, Inc.
dba Aetna Better Health of Florida
1340 Concord Terrace
Sunrise, FL 33323
(954) 858-3495
GarwoodH@aetna.com

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

SRC# 32 – Fraud and Abuse Special Investigations Unit (SIU) (Statewide):

The respondent shall describe its Special Investigations Unit (SIU) program and its controls for prevention and detection of potential or suspected fraud and abuse and overpayment, including the use of biometric or other technology to ensure that services are provided to the correct enrollee, including verification of home-based visits and services, to ensure those services are being appropriately provided and that services billed were received by the correct enrollee.

Response:

Our core values of excellence and integrity align with the Agency's objectives to promote responsibility and accountability in the delivery of high-quality, cost-effective health care. Prevention, detection, and correction of instances of fraud, waste, and abuse and overpayment are vital to that commitment. In 2016, our Medicaid Special Investigations unit's (SIU) avoidance, recovery, prevented loss, overpayment recovery, and overall vendor cost avoidance activities resulted savings in Florida of $2,870,905.

Aetna has the expertise and is committed to collaborating with State and federal agencies to combat Medicaid fraud, waste, abuse, and overpayment. We were a founding member of the National Health Care Anti-Fraud Association (NHCAA) and the Medical Identity Fraud Alliance. In addition, we are a member of the National Association of Medicaid Program Integrity, the Centers for Medicare & Medicaid Services (CMS) Health Care Fraud Prevention Partnership, and the CMS Healthcare Anti-Fraud Task Force. As part of our strategy for preventing health care fraud, our SIU detects fraud, abuse, waste, and overpayment through a number of activities and sources.

SPECIAL INVESTIGATIONS UNIT PROGRAM

Aetna's corporate SIU senior director oversees Aetna-wide activities related to the prevention, investigation, prosecution, and reporting of health care fraud, as well as to the recovery of lost funds. Medicaid investigations supervisors assist with activities related to fraud, waste, and abuse for all Aetna Medicaid plans, and they report and coordinate activities with the local compliance officer. The SIU has Medicaid-dedicated staff who support all of our health plans, including senior investigators, senior analysts, a business project program manager, an information technology project lead, and supervisors who report to the Medicaid special investigations manager. These staff members possess backgrounds in pharmacy, coding, fraud examination, Medicaid compliance, nursing, law, and law enforcement. This team also has a dedicated senior medical director who reviews and consults on fraud, waste, and abuse issues.
SIU investigators receive specialized training focused on the investigative process, key State and federal regulations, processes and procedures for addressing suspicious claims, and the procedure for facilitating communication among the health plan, appropriate authorities, and the SIU. In-person and Web-based training sessions held by NHCAA provide additional opportunities to improve investigator skills as well as learn about new schemes trending in the industry.

The SIU presents case reports to Aetna's compliance director and the Fraud, Waste, and Abuse Committee, which includes senior plan leadership and representatives from the Compliance,

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Medical Management, Provider Services, Finance, and Legal departments. The committee reviews the case and develops a corrective action plan to resolve the issue in a fair, effective, and appropriate manner. Aetna employs a process for timely, complete, and consistent exchange of information and collaboration with the Agency's designated agents and contracted external quality review organizations.

Upon detection of potential fraud, waste, or abuse at the local level, Florida-based investigator [redacted] works closely with our Compliance Officer [redacted], and leads the investigative process. When our compliance officer receives referrals, she will forward them to [redacted], who notifies [redacted] when an investigation is opened so that she can help to ensure compliance with State guidelines, rules, and regulations. She will report new cases to AHCA within 15 days. The investigation is documented in a case-tracking database and stored securely. The database allows easy access to all case files and contains pre-programmed reporting to track and manage the investigations. At the conclusion of an investigation, [redacted] files a report, including the allegation, an executive summary, case notes, and recommendations such as a recovery figure and suggested corrective actions. He provides updates to [redacted] regarding the status of open cases, and she reports the status to AHCA's Medicaid Program Integrity division on a quarterly and annual basis.

CONTROLS AND AUTOMATED APPROACHES FOR PREVENTION AND DETECTION

CRITERION 1: The extent to which the respondent uses various types of controls and automated approaches as part of a comprehensive approach to prevent and detect potential or suspected fraud and abuse and overpayment

Aetna uses a variety of controls and automated approaches as part of our comprehensive approach to prevent and detect potential or suspected fraud and abuse and overpayment. A brief discussion of some of these controls follows.

Front-end Claims Editing

We collaborate with industry leaders such as McKesson ClaimCheck and Cotiviti Healthcare for front-end automation of correct-coding and medical-policy decisions specific to Medicaid and Medicare and for supporting the detection of coding irregularities, conflicts, or errors while making recommendations for correction. Our claim system and editing vendors perform edits for enrollee data (e.g., age, gender), provider data, current coding protocol, assistant surgeon, place of service, type of bill, medical visit logic, medical unlikeliness, durable medical equipment, new-visit frequency, and professional, technical, and global services.

Data Analytics and Predictive Modeling

The SIU profiles providers by peer group, specialty, product, and geography, among other relevant groupings. We use business intelligence software to identify providers whose billing, treatment, or patient demographic profiles differ significantly from those of their peers. Our SIU's internal analytics staff runs case- and scheme-specific reports using structured query language, Statistical Analysis System software, and Crystal reporting technology to support current investigations and identify new cases. The SIU performs an annual review of the plan to identify high-dollar specialties, providers, and procedures codes. This can suggest to our SIU investigators which specialties to review for outlier behavior.